

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2010
FORM APPROVED
OMB NO. 0968-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/14/2010
NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 683 E. THIRD STREET RUSSELLVILLE, KY 42276		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An annual survey and an abbreviated survey (KY #15440) was conducted on 10/12/10 through 10/14/10 to determine the facility's compliance with Federal requirements. The facility failed to meet requirements for recertification with the highest S/S of "E". KY #15440 was substantiated with deficiencies cited.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement in full or in part, by the provider, of the truth of the fact, or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provisions set forth in Federal and State Law.		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure the provision of personal privacy by ensuring the privacy curtains are pulled during care. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: Staff identified as providing care for residents (#1, #6, #8, and #20) were re-educated on 10/13/10 by the Administrator regarding the need to pull privacy curtains during care. They will also be re-educated along with remaining staff thru 12/8/10 by the Staff Development Coordinator regarding providing visual privacy. Residents (#1, #6, #8, and #20) are being provided personal privacy by staff pulling the privacy curtains during their care. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: All residents were identified as having the need for visual privacy during care, therefore staff for all residents were re-educated as described below. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: Re-education was provided to staff including nursing assistants, medication aides, and licensed nurses on 10/13/10, 10/14/10, 10/15/10, 10/16/10, 10/21/10, and 10/25/10		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure the provision of personal privacy by ensuring the privacy curtains were pulled during care for three residents (#1, #6 and #8), in the selected sample of 19 and one resident (#20), not in the selected sample. Findings include:</p> <p>A review of the facility's policy/procedure, "Rights of Nursing Home Residents", which was not dated, revealed nursing home residents had the right to privacy in medical treatment and the right to be treated equally and with dignity.</p> <p>1. A record review revealed Resident #1 was admitted to the facility on 07/19/10. A review of a quarterly Minimum Data Set (MDS), dated 09/28/10, revealed the facility identified Resident #1 as cognitively independent and required extensive assistance with bed mobility and transfers. The MDS revealed the resident had an indwelling catheter and was incontinent of bowel.</p> <p>An observation, on 10/13/10 at 1:00 PM, revealed staff did not ensure privacy during provision of wound/catheter care for Resident #1, by pulling the privacy curtain. The curtain was open and the resident was visible to anyone entering the resident's room.</p> <p>Interviews with Licensed Practical Nurse (LPN) #1, on 10/13/10 at 1:10 PM and Certified Nurse Aide (CNA) #1, on 10/13/10 at 1:40 PM respectively, revealed the privacy curtain should have been pulled around Resident #1 while providing care.</p>	F 164	<p>related to the requirement to provide personal privacy with an emphasis on the use of privacy curtains to provide visual privacy during care. This education was conducted by the Administrator and the Staff Development Coordinator.</p> <p>Further re-education related to the requirement to provide personal privacy by use of privacy curtains during resident care will be provided to all nursing staff, including nursing assistants, medication aides, and licensed nurses not previously trained in training sessions scheduled from 10/13-10/25/10. Training will be continued with staff who have not been trained through 11/12/10. This training will be provided or coordinated by the Staff Development Coordinator. Any person not trained by 11/12/10 will be trained on their next scheduled day of work before beginning their shift. The staffing coordinator will be responsible for arranging or providing training to anyone scheduled to work after 11/12/10 who has not yet been trained.</p> <p>HOW CORRECTIVE ACTIONS WILL BE MONITORED:</p> <p>A 10% sample of residents will be selected by the QA committee to be observed during care to verify that visual privacy is provided. These observations will be conducted daily for seven (7) days, then weekly for three (3) weeks, and then monthly for a duration of time to be determined by the QA committee. The sample will include residents on all units and will be conducted on all shifts. Designees from the QA committee to include the Staff Development Coordinator, QA nurse, ADON, MDS Coordinators, DON, and Administrator will be assigned to observe staff members providing care to the sample of residents to verify the provision of personal privacy by pulling privacy curtains during care.</p>	11/13/10	

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F 164	<p>Continued From page 2</p> <p>An interview with Nurse Aide (NA) #1, on 10/13/10 at 1:20 PM, revealed she realized privacy was not provided for Resident #1. She stated, "The privacy curtain should have been pulled just in case someone entered the room without knocking on the door."</p> <p>2. A record review revealed Resident #6 was admitted to the facility on 07/14/10. A review of the quarterly MDS, dated 08/26/10, revealed the facility identified Resident #6 as cognitively independent and required extensive assistance with bed mobility.</p> <p>An observation, on 10/13/10 at 9:40 AM, revealed privacy was not provided for Resident #6 during provision of wound care. The privacy curtain was not pulled and the resident was visible to anyone entering the resident's room during the care.</p> <p>An interview with LPN #1, on 10/13/10 at 1:10 PM, revealed he did not pull the privacy curtain for Resident #6, because the resident did not have a roommate. He stated, "I should have pulled the curtain because someone could have walked in the room."</p> <p>An interview with CNA #1, on 10/13/10 at 1:40 PM, revealed she was aware of the potential for someone to enter the resident's room during wound care. She stated the privacy curtain should have been utilized.</p> <p>3. A record review revealed Resident #8 was admitted to the facility on 03/15/10. A review of a quarterly MDS, dated 08/13/10, revealed the facility identified Resident #8 as cognitively independent and required extensive assistance</p>	F 164			

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F 164	<p>Continued From page 3</p> <p>with bed mobility and transfers. The MDS revealed the resident had an indwelling catheter and was frequently incontinent of bowel.</p> <p>An observation, on 10/13/10 at 2:20 PM, revealed Registered Nurse (RN) #1 did not ensure personal privacy during provision of a skin assessment. The privacy curtain was pulled separating Resident #8 from his/her roommate; however, the curtain was not pulled completely around the resident's bed to ensure visual privacy from anyone opening the door or entering the room.</p> <p>An interview with RN #1, on 10/14/10 at 1:34 PM, revealed she thought both curtains had been pulled.</p> <p>4. A record review revealed Resident # 20 was admitted to the facility on 05/19/10. A review of the quarterly MDS assessment, dated 08/15/10, revealed the facility identified Resident #20 as severely cognitively impaired, frequently incontinent of bowel and bladder and required extensive assistance of two staff for transfers and toileting.</p> <p>An observation, on 10/14/2010 at 9:32 AM, revealed the resident's door was closed. This surveyor knocked on the resident's door. CNA #2 opened the door and observation revealed Resident #20 was on a bedside commode. The privacy curtain was not drawn around the resident's bed to provide visual privacy. The resident was exposed in full view to his/her roommate and anyone entering the room or in the hallway.</p> <p>An interview with CNA #2, on 10/14/2010 at 1:15</p>	F 164			

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F 164	Continued From page 4 PM, revealed she did not pull the privacy curtain due to the privacy curtain was very hard to pull. An interview with the Director of Nursing, on 10/14/10 at 9:55 AM, revealed she expected staff to provide privacy and pull privacy curtains during care. She stated, "It would be ideal to pull the privacy curtain in a resident's room, even if the resident does not have a roommate."	F 164			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on Interviews and record review, it was determined the facility failed to ensure services were provided in accordance with the care plan for one resident (#9), in the selected sample of 19. On 09/09/10, Resident #9 sustained a fall from a shower bed in the shower room. One staff member was providing the bath. The resident had been assessed and care planned for the assistance of two staff, while in the shower room. Findings include: A review of the facility's policy/procedure, "Comprehensive Care Plans", dated 09/17/09, revealed "The plan of care will be stated clearly and will identify the resident problem, measurable goals to be achieved, which include timetables to meet resident's needs, and the intervention to be followed by staff in providing the resident care. Each approach will identify the discipline	F 282	F 282 It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure services are provided by qualified personnel in accordance with each resident's written plan of care. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: Nursing staff responsible for providing care to resident (#9) were re-educated on 9/9/10 by the ADON, DON, QA Nurse, and Staff Development Coordinator to provide showers to resident (#9) with the assistance of two staff members in accordance with her written plan of care. Resident (#9) is receiving showers with the assistance of two staff members in accordance with her written plan of care.		

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F 282	<p>Continued From page 5 responsible for the care delivery."</p> <p>A record review revealed Resident #9 was admitted to the facility, on 01/15/07, with diagnoses to include Urinary Tract Infection and Late Effect Cerebrovascular Accident.</p> <p>A review of the annual Minimum Data Set (MDS), dated 08/17/10, revealed the facility identified the resident as moderately cognitively impaired, required extensive assistance of two staff with bed mobility and transfers, was non-ambulatory and required total assistance of two staff with bathing. Resident #9 had left sided paralysis from a past stroke and was not interviewable.</p> <p>A review of the resident's Comprehensive Care Plan, "Self Care Deficit," dated 08/17/10, revealed interventions to include: "Total assistance of two with shower; shower two times per week; Partial bath on in-between day; Uses shower bed." A review of the "Nurse Aide Data Sheet," dated 08/18/10, revealed the resident required assistance of two staff in the shower, using a shower bed.</p> <p>A review of the nurse's note, dated 09/09/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 was summoned to the shower room and observed Resident #9 lying on his/her back on the floor. Staff reported the resident rolled off the shower bed. The nurse assessed the resident as alert and verbal and a small abrasion was noted on the left side of the resident's chin and right knee. The resident was transferred by four staff members from the floor to the shower bed, using a sheet. The resident complained of a headache and neuro-checks were initiated, which were within normal limits. The physician was notified.</p>	F 282	<p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED:</p> <p>The written plan of care for current residents was reviewed by the ADON and QA nurse to identify residents requiring assistance of more than one staff member for showers. The review was completed by 9/15/10.</p> <p>MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE:</p> <p>Re-education was provided 9/9/10 thru 9/20/10 and again 10/13/10 thru 10/16/10 and again 10/21/10 and 10/25/10 to staff including nursing assistants, med techs, and licensed nurses on consistently providing care in accordance with each residents written plan of care to reinforce the requirement to follow the planned amount of assistance for the provision of baths and showers.</p> <p>Education will be provided upon hire to staff including nursing assistants, med techs, and licensed nurses on following the residents' written plan of care and reviewing the NADS daily.</p> <p>HOW CORRECTIVE ACTIONS WILL BE MONITORED:</p> <p>Unscheduled observations of staff members providing assistance to residents requiring assistance of more than one for showers were done 9/17/10 thru 10/19/10 by designated members of the QA committee including the ADON, DON, QA nurse, MDS coordinator, and Staff Development Coordinator.</p> <p>QA committee members including the ADON,</p>		

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F 282	<p>Continued From page 6</p> <p>Further review of the nurses' note revealed approximately an hour later, the resident complained of chest pain and was transferred to the hospital at 10:45 AM. The resident returned by ambulance at 1:20 PM.</p> <p>An interview with Certified Nurse Aide (CNA) #4, on 10/13/10 at 9:15 AM, revealed two CNAs had assisted her to transfer Resident #9 from his/her chair to the shower bed. The CNAs offered to assist with the resident's bath; however, she told the other staff she did not need assistance with the resident's care provision after the transfer. She stated she was aware the resident's care plan required two staff assistance with transfers; however, she was unsure about the amount of staff required for assistance in the shower room. She stated she did not refer to the care plan to review the interventions required in the shower. CNA #4 revealed the shower bed was against the wall; however, both sides of the shower bed were lowered and the resident slipped away from her. She stated she had not provided the resident's shower without assistance prior to the incident.</p> <p>An interview with LPN #2, on 10/13/10 at 1:20 PM, revealed the facility had assessed the resident to require total assist with all activities of daily living, except feeding him/herself. After the fall, the resident was transferred to bed and sent to the hospital about an hour later for complaints of chest pain. The resident returned to the facility the same day, with a "possible" left clavicle fracture.</p> <p>An interview with the Director of Nursing, on 10/14/10 at 10:45 AM, revealed the resident did not complain of pain and there were no apparent injuries as a result of the fall; however, the</p>	F 282	<p>DON, QA nurse, MDS coordinator, and Staff Development Coordinator will continue to randomly observe a minimum of ten (10) showers per week of residents that require more than one assist at unannounced times for four (4) weeks, then a minimum of ten showers per month for a period of time to be determined by the QA committee. Observations will include staff on 1st and 2nd shifts (there are no scheduled showers on 3rd shift) and will be to verify the number of staff assisting with the shower is in accordance with the residents' written plan of care without deviation.</p> <p>The QA committee may increase the frequency or duration of observations if concerns are identified. Conversely, if no areas of concern are identified the frequency and duration of monitoring may be decreased.</p> <p>Continued education will be provided to staff including nurse techs, med techs, and licensed nurses at a minimum of quarterly for the next nine months and then annually.</p>	10/26/10	

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F 282	Continued From page 7 resident was sent to the hospital about an hour after the fall, due to complaints of chest pain. She stated CNA #4 had plenty of staff assistance available on the day the resident fell and she expected all CNAs to review care plans every shift. An interview with the administrator, on 10/14/10 at 2:30 PM, revealed an investigation was initiated immediately after the resident's fall and the facility investigation revealed the care plan was not followed by CNA #4. She expected CNA #4 to review and follow the care plans daily.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for one resident (#9), in the selected sample of 19. According to the resident's care plan, the resident required assistance of two staff while in the shower room on a shower bed. On 09/09/10, Resident #9 sustained a fall from the shower bed in the shower room, while being assisted by one staff member. Findings include:	F 323	F 323 It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE: Nursing staff responsible for providing care to resident (#9) were re-educated on 9/9/10 by the ADON, DON, QA nurse, and Staff Development Coordinator to provide showers to resident (#9) with the assistance of two in accordance with her written plan of care to enhance safety. Resident (#9) is receiving showers with the assistance of two staff members in accordance with her written plan of care.	

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F 323	Continued From page 8 A review of the facility's policy/procedure, "Falls", dated 06/01/10, revealed "The falls risk analysis should be completed upon admission, quarterly and with significant change in condition affecting the resident's function status using the state specific form. Based on the analysis, preventive/safety measures will be implemented, as appropriate, for residents identified at risk for falls." A record review revealed Resident #9 was admitted to the facility, on 01/15/07, with diagnoses to include Urinary Tract Infection and Late Effect Cerebrovascular Accident. A review of the annual Minimum Data Set (MDS), dated 08/17/10, revealed the facility identified Resident #9 as moderately cognitively impaired and required extensive assistance of two staff with bed mobility and transfers. Resident #9 was non-ambulatory and required total assistance of two staff with bathing. The resident had a left-sided paralysis from a previous stroke and repetitious movements of the right arm, at times. The resident was assessed as 5' 9" tall and weighed 202 #. A review of a falls risk analysis, dated 08/12/10, revealed the facility assessed the resident as at high risk for falls. A review of the Comprehensive Care Plan for "Self Care Deficit" dated 08/17/10, revealed interventions included: "Total assistance of two with shower, shower two times per week. Uses shower bed." A review of the "Nurse Aide Data Sheet," dated 08/18/10, revealed the resident required the assistance of two staff in the shower,	F 323	HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED: The written plan of care for current residents was reviewed by the ADON and the QA nurse to identify residents requiring assistance of more than one staff member for showers to promote safety. The review was completed by 9/15/10. MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE: Re-education was provided 9/9/10 thru 9/20/10 and again 10/13/10 thru 10/16/10, and again 10/21/10 and 10/25/10 to staff including nurse techs, med techs, and licensed nurses on consistently providing care in accordance with each residents' written plan of care to reinforce the requirement to follow the planned amount of assistance for the provision of baths and showers. Education will be provided upon hire to staff including nursing assistants, med techs, and licensed nurses on following the residents' written plan of care and reviewing the residents' NADS daily so that they are aware of the plan for services to provide care in a manner that allows the residents' environment to be as free of hazards as possible and to provide adequate supervision and assistance to avoid accidents when possible. HOW CORRECTIVE ACTIONS WILL BE MONITORED: Unscheduled observations of residents requiring assistance of more than one for showers to verify that assistance was provided as specified on the Nurse Aide Data Sheet were conducted from 9/17/10 thru 10/19/10 by designated members of the QA committee including the ADON, DON, QA nurse, MDS coordinator, and Staff Development Coordinator.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/14/2010
NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 683 E. THIRD STREET RUSSELLVILLE, KY 42276		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 9 using a shower bed.</p> <p>A review of the nurses' note, dated 09/09/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 was summoned to the shower room and she observed Resident #9 lying on his/her back, on the floor. Staff reported the resident had rolled off the shower bed. The resident was assessed as alert and verbal and a small abrasion was noted on the left side of the resident's chin and right knee. Four staff members transferred the resident back to the shower bed, using a sheet. The resident complained of a headache and neuro-checks were initiated, which were within normal limits and the physician was notified. Further review of the nurses' note revealed the resident complained of chest pain at approximately 10:30 AM and was transferred to the hospital, for evaluation. The resident returned to the facility at approximately 1:20 PM.</p> <p>A review of the facility's final investigation, dated 09/14/10, revealed CNA #4 was alone in the shower room providing Resident #9 a shower on the shower bed. The CNA had the shower bed positioned against the wall and felt the shower bed move. The resident was positioned on his/her left side at the time. CNA #4 stated she felt the resident slipping away from her and the resident fell to the floor onto his/her left side, between the wall and the back of the shower bed. The CNA called for assistance and the DON and LPNs #1 and #3 responded. There were no complaints of pain upon the initial assessment completed by the DON. Prior to the fall, CNA #4 stated she received assistance from two other CNAs to transfer the resident from his/her chair to the shower bed. CNA #4 "thought" she could give the resident a shower without assistance and did not</p>	F 323	<p>QA committee members including the ADON, DON, QA nurse, MDS coordinator, and Staff Development Coordinator will continue to randomly observe a minimum of ten (10) showers per week of residents that require more than one assist at unannounced times, for four weeks, then a minimum of ten (10) showers per month for a period of time to be determined by the QA committee, to verify that adequate assistance is provided to avoid accidents when possible.</p> <p>Observations will include staff on 1st and 2nd shifts (there are no scheduled showers on 3rd shift) and will be to verify the number of staff assisting with the shower is in accordance with the resident's written plan of care.</p> <p>The QA committee may increase the frequency or duration of observations if concerns are identified. Conversely, if no areas of concern are identified the frequency and duration of monitoring may be decreased.</p> <p>Continued education will be provided to staff including nursing assistants, med techs, and licensed nurses at a minimum of quarterly for the next nine months and then annually.</p>	10/26/10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 10</p> <p>realize the resident was care planned for assistance of two staff with showers.</p> <p>A review of the "Diagnostic Imaging," dated 09/09/10, revealed "Findings suspicious for distal Clavicular fracture." A review of follow-up "Diagnostic Imaging," dated 09/16/10, revealed, "Fracture of the distal left Clavicle. AC joint injury is certainly possible. If anything there has been further elevation of the Clavicle in relation to the Acromion process." Further review of an orthopaedic/neurosurgical report, dated 09/29/10, revealed, "Shows questionable old fracture of the distal end of the Clavicle with callus formation. No obvious AC joint."</p> <p>An interview with CNA #4, on 10/13/10 at 9:15 AM, revealed she and two other CNAs transferred Resident #9 from his/her chair to the shower bed. However, when asked by the other CNAs if she needed assistance with the shower, she told the CNAs she could handle it alone. She stated she knew the resident was an assist of two staff with transfers, but she was unsure about assistance required in the shower. She stated she did not check the care plan prior to providing the care. The shower bed was against the wall and both sides of the shower bed were lowered. The resident slipped away from her and fell to the floor. She stated she had not completed the resident's shower alone, prior to the incident. She just felt she could handle it.</p> <p>An interview with CNA #5, on 10/13/10 at 1:40 PM, revealed she and another CNA assisted CNA #4 with the transfer of Resident #9 from the chair to the shower bed on 09/09/10; however, CNA #4 told them she could handle the shower alone.</p>	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 11 An interview with LPN #2, on 10/13/10 at 1:20 PM, revealed the resident was assessed and care planned as a total assist with all of his/her activities of daily living, except for feeding him/herself. After the fall, the resident was transferred back to bed; however, he/she was sent to the hospital about an hour later due to complaints of chest pain. The resident returned to the facility the same day with a possible fracture of the left clavicle. An interview with the Director of Nursing, on 10/14/10 at 10:45 AM, revealed she completed the initial assessment after the resident's fall. The resident did not complain of pain and there were no apparent injuries. However, the resident was sent to the hospital about an hour after the fall, due to complaints of chest pain. She stated CNA #4 had available assistance and she expected all CNAs to review care plans every shift. An interview with the administrator, on 10/14/10 at 2:30 PM, revealed an investigation was completed after the resident's fall and found the staff had not followed the care plan. She expected CNA #4 to review and follow care plans daily. As a result of the CNA not reviewing or following the care plan, the resident had sustained a fall.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F441 It is the normal practice of Creekwood Place Nursing and Rehab Center to require that staff wash their hands after each direct resident contact.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 12</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews and record reviews, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which handwashing was indicated for two residents (#1 and #6), in the selected sample of 19.</p> <p>Findings include:</p>	F 441	<p>CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE:</p> <p>Staff identified as not washing their hands while caring for residents (#1 and #6) were provided re-education on 10/13/10 by the Administrator on washing their hands after each direct resident contact and following proper hand hygiene practices.</p> <p>Staff are now following proper hand hygiene practices after each direct resident contact for residents (#1 and #6).</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED:</p> <p>All residents were identified as requiring staff wash their hands after each direct resident contact, therefore all staff were provided re-education on hand washing as described below.</p> <p>MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE:</p> <p>Re-education was provided by the Administrator and Staff Development Coordinator to staff including nurse techs, med techs, and licensed nurses 10/13/10, 10/14/10, 10/15/10, 10/16/10, 10/21/10, and 10/25/10 related to staff washing their hands after each direct resident contact.</p> <p>Further re-education related to the requirement of following proper hand hygiene practices after resident contact will be provided 11/8/10 thru 11/12/10 to staff including nursing assistants, medication aides, and licensed nurses not previously re-educated on earlier mentioned dates. This re-education will be done by the Staff Development Coordinator.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 13</p> <p>A review of the policy/procedure, "Infection Control", which was undated, revealed the most important way to prevent the spread of infection was handwashing. This was to be completed before and after resident care, even if gloves were used.</p> <p>1. A record review revealed Resident #1 was admitted to the facility, on 07/19/10, with diagnoses to include Pressure Ulcer, Urinary Tract Infection, and Respiratory System Disease.</p> <p>A review of a quarterly Minimum Data Set (MDS), on 09/28/10, revealed the facility identified Resident #1 as cognitively independent and required extensive assistance with bed mobility and transfers. The MDS revealed the resident had an indwelling catheter and was incontinent of bowel.</p> <p>An observation of the provision of wound/catheter care, on 10/13/10 at 1:00 PM, revealed Licensed Practical Nurse (LPN) #1 did not wash his hands, prior to donning gloves. After care was provided by Certified Nurse Aide (CNA) #1, who did not take off her contaminated gloves before touching different objects in the resident's room. For example, she used the control to lower the resident's bed, touched the resident's bedside table and adjusted the resident's linen on the bed before removing the gloves.</p> <p>An interview with LPN #1, on 10/13/10 at 1:10 PM, revealed he should have washed his hands before and after providing care for Resident #1.</p> <p>An interview with CNA #1, on 10/13/10 at 1:40 PM, revealed she should have removed her</p>	F 441	<p>HOW CORRECTIVE ACTIONS WILL BE MONITORED:</p> <p>A 10% sample of residents will be selected by the QA committee daily for seven (7) days, then weekly for three (3) weeks, and then monthly for a duration of time to be determined by the QA committee based on findings of previous review of hand washing observations. The sample will include residents on all units. Designees from the QA committee including the ADON, QA nurse, DON, and Staff Development Coordinator will randomly observe staff members on each shift providing care to the sample of residents to verify that staff are following appropriate hand hygiene practices after each direct resident contact.</p> <p>The QA Committee may increase the frequency or duration of observations if concerns are identified. Conversely, if no areas of concern are identified the frequency and duration of monitoring may be decreased.</p>	11/13/10	

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F 441	<p>Continued From page 14</p> <p>gloves after providing care for Resident #1. She stated, "I usually do."</p> <p>2. A record review revealed Resident #6 was admitted to the facility on 07/14/10. A review of the quarterly MDS, dated 08/26/10, revealed the facility identified Resident #6 as cognitively independent and required extensive assistance with bed mobility.</p> <p>An observation of the provision of wound care, on 10/13/10 at 9:40 AM, revealed LPN #1 cleansed the resident's coccyx wound and then realized he needed a Q-tip to measure the wound. Nurse Aide (NA) #1 removed her gloves and left the room and obtained a Q-tip without washing her hands. LPN #1 removed his gloves and left the room without washing his hands. NA #1 and LPN #1 returned to the resident's room, donned gloves without washing their hands and provided care. After provision of care, NA #1 walked out into the hallway and retrieved the resident's wheelchair, while wearing the contaminated gloves. She returned to the room with the wheelchair, removed her gloves and washed her hands.</p> <p>An interview with LPN #1, on 10/13/10 at 1:10 PM, revealed he did not wash his hands after removing his soiled gloves.</p> <p>An interview with NA #1, on 10/13/10 at 1:20 PM, revealed she should have washed her hands before providing care for Resident #6 and after removing her gloves.</p> <p>An interview with the Director of Nursing, on 10/14/10 at 9:55 AM, revealed staff should wash their hands before providing resident care and after removing their soiled gloves. She expected</p>	F 441			

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F 441	Continued From page 15 staff to follow the facility policy for handwashing.	F 441			

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K 000	INITIAL COMMENTS	K 000			
K 147 SS=D	<p>A Life Safety Code Survey was conducted on 10/14/10 to determine Federal compliance with Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency at an D.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure compliance with NFPA 70 National Electric Code 1999 Edition relating to ground fault protection for all electrical receptacles near a water source. This condition affected two residents.</p> <p>Examples include: During the Life Safety Code Inspection tour conducted, on 10/14/10 at approximately 10:00 AM, a light fixture located over the sink in the bathroom of Resident Room #114 was observed to have a 125 volt receptacle which was not ground fault protected (GFCI).</p> <p>An interview with the Director of Maintenance at this time revealed he was aware that some of the light fixtures contained a receptacle, but had not thought about them not being ground fault protected.</p>	K 147	<p>K147</p> <p>It is the normal practice of Creekwood Place Nursing and Rehab for electrical wiring and equipment to be in accordance with NFPA 70, National Electric Code .9.1.2. relating to ground fault protection for all electrical receptacles near a water source.</p> <p>CORRECTIVE ACTION FOR RESIDENTS AFFECTED BY THIS PRACTICE:</p> <p>The light fixture located over the sink in the bathroom of Resident Room # 114 was removed.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WERE IDENTIFIED:</p> <p>All other electrical receptacles near water sources were checked to ensure compliance with NFPA 70 National Electric Code 9.1.2 relating to ground fault protection for electrical receptacles near water sources. Receptacles not in compliance with this code were removed.</p> <p>MEASURES OR SYSTEMIC CHANGES TO PREVENT RECURRENCE:</p> <p>Education was provided to maintenance staff on 10/13/10 relating to all electrical receptacles near water sources requiring ground fault protection.</p> <p>Any electrical receptacles installed near water sources will be checked by Maintenance staff to verify ground fault protection and compliance with NFPA 70, National Electric Code 9.1.2.</p>	10/15/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Eugene H. Perkins

TITLE

Administrator

(X6) DATE

11/17/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 147	Continued From page 1 Reference to: NFPA 70 National Electric Code 1999 Edition 210-8. Ground-Fault Circuit-Interrupter Protection for Personnel (a) Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified below shall have ground-fault circuit-interrupter protection for personnel. 1. Bathrooms.	K 147	HOW CORRECTIVE ACTIONS WILL BE MONITORED: After completion of repairs, rounds will be conducted by the Administrator or Maintenance Director annually to verify that all electrical receptacles installed near water sources are equipped with ground fault protection. Any electrical repairs completed on receptacles near a water source will be reviewed by the Director of Maintenance to verify that it has ground fault protection on an ongoing basis.		